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105TH CONGRESS
1ST SESSION

H. R. 815

To amend the Internal Revenue Code of 1986, the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and titles XVIII and XIX of the Social Security Act to assure access to emergency medical services under group health plans, health insurance coverage, and the Medicare and Medicaid Programs.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 25, 1997

Mr. CARDIN (for himself, Mrs. ROUKEMA, Mr. DINGELL, Mr. SHAYS, Mr. STARK, Mr. DAVIS of Virginia, Mr. WAXMAN, Mr. CONDIT, Mr. BROWN of Ohio, Mr. KENNEDY of Rhode Island, Mr. POMEROY, Mrs. THURMAN, Mr. GEJDENSON, Mrs. MEEK of Florida, Mr. CLEMENT, Mr. DOYLE, Mr. NORWOOD, Mr. LEVIN, Mr. EVANS, Mr. MCDERMOTT, Mr. FROST, Mr. CAMPBELL, Mr. CONYERS, Mr. RAHALL, Mr. MCGOVERN, and Mr. GANSKE) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce, and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Internal Revenue Code of 1986, the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and titles XVIII and XIX of the Social Security Act to assure access to emergency medical services under group health plans, health insurance coverage, and the Medicare and Medicaid Programs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Access to Emergency Medical Services Act of 1997".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Amendments to the Internal Revenue Code of 1986.
Sec. 3. Amendments to the Employee Retirement Income Security Act of 1974.
Sec. 4. Amendments to the Public Health Service Act relating to the group market.
Sec. 5. Amendments to the Public Health Service Act relating to the individual market.
Sec. 6. Application to private coverage for medicare and medicaid beneficiaries.
Sec. 7. Establishment of guidelines.

SEC. 2. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

(a) IN GENERAL.—Subtitle K of the Internal Revenue Code of 1986 (as added by section 401(a) of the Health Insurance Portability and Accountability Act of 1996) is amended—

(1) by striking all that precedes section 9801 and inserting the following:

"Subtitle K—Group Health Plan Requirements

"CHAPTER 100. Group health plan requirements.

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"CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

"Subchapter A. Requirements relating to portability, access, and renewability.
"Subchapter B. Other requirements.
"Subchapter C. General provisions.

"Subchapter A—Requirements Relating to Portability, Access, and Renewability

"Sec. 9801. Increased portability through limitation on preexisting condition exclusions.
"Sec. 9802. Prohibiting discrimination against individual participants and beneficiaries based on health status.
"Sec. 9803. Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements.",

(2) by redesignating sections 9804, 9805, and 9806 as sections 9831, 9832, and 9833, respectively,

(3) by inserting before section 9831 (as so redesignated) the following:

"Subchapter C—General Provisions

"Sec. 9831. General exceptions.
"Sec. 9832. Definitions.
"Sec. 9833. Regulations.", and

(4) by inserting after section 9803 the following:

"Subchapter B—Other Requirements

"Sec. 9811. Assuring equitable coverage of emergency services, maintenance care, and post-stabilization care.

"SEC. 9811. ASSURING EQUITABLE COVERAGE OF EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.

"(a) PROHIBITION OF CERTAIN RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—

"(1) IN GENERAL.—If a group health plan provides any benefits with respect to emergency services (as defined in paragraph (2)(B)), the plan (and any health insurance issuer offering health insurance coverage in connection with such a plan) shall cover emergency services furnished to a participant or beneficiary of the plan—

"(A) without the need for any prior authorization determination,

"(B) subject to paragraph (3), whether or not the physician or provider furnishing such services is a participating physician or provider with respect to such services, and

"(C) subject to paragraph (3), without regard to any other term or condition of such plan or coverage (other than an exclusion of benefits, or an affiliation or waiting period, permitted under section 9801).

"(2) EMERGENCY SERVICES; EMERGENCY MEDICAL CONDITION.—For purposes of this section—

"(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

"(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

"(ii) serious impairment to bodily functions, or

"(iii) serious dysfunction of any bodily organ or part.

"(B) EMERGENCY SERVICES.—The term 'emergency services' means—

"(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a

hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition (as defined in subparagraph (A)), and

"(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient.

"(C) TRAUMA AND BURN CENTERS.—The provisions of clause (ii) of subparagraph (B) apply to a trauma or burn center, in a hospital, that—

"(i) is designated by the State, a regional authority of the State, or by the designee of the State, or

"(ii) is in a State that has not made such designations and meets medically recognized national standards.

"(3) APPLICATION OF NETWORK RESTRICTION PERMITTED IN CERTAIN CASES.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), if a group health plan (and

an issuer of health insurance coverage in connection with such a plan) denies, limits, or otherwise differentiates in coverage or payment for benefits other than emergency services on the basis that the physician or provider of such services is a nonparticipating physician or provider, the plan and issuer may deny, limit, or differentiate in coverage or payment for emergency services on such basis.

"(B) NETWORK RESTRICTIONS NOT PERMITTED IN CERTAIN EXCEPTIONAL CASES.—The denial or limitation of, or differentiation in, coverage or payment of benefits for emergency services under subparagraph (A) shall not apply in the following cases:

"(i) CIRCUMSTANCES BEYOND CONTROL OF PARTICIPANT OR BENEFICIARY.—The participant or beneficiary is unable to go to a participating hospital for such services due to circumstances beyond the control of the participant or beneficiary (as determined consistent with guidelines and subparagraph (C)).

"(ii) LIKELIHOOD OF AN ADVERSE HEALTH CONSEQUENCE BASED ON

LAYPERSON'S JUDGMENT.—A prudent layperson possessing an average knowledge of health and medicine could reasonably believe that, under the circumstances and consistent with guidelines, the time required to go to a participating hospital for such services could result in any of the adverse health consequences described in a clause of subsection (a)(2)(A).

"(iii) PHYSICIAN REFERRAL.—A participating physician or other person authorized by the plan refers the participant or beneficiary to an emergency department of a hospital and does not specify an emergency department of a hospital that is a participating hospital with respect to such services.

"(C) APPLICATION OF 'BEYOND CONTROL' STANDARDS.—For purposes of applying subparagraph (B)(i), receipt of emergency services from a nonparticipating hospital shall be treated under the guidelines as being 'due to circumstances beyond the control of the participant or beneficiary' if any of the following conditions are met:

"(i) UNCONSCIOUS.—The participant or beneficiary was unconscious or in an otherwise altered mental state at the time of initiation of the services.

"(ii) AMBULANCE DELIVERY.—The participant or beneficiary was transported by an ambulance or other emergency vehicle directed by a person other than the participant or beneficiary to the nonparticipating hospital in which the services were provided.

"(iii) NATURAL DISASTER.—A natural disaster or civil disturbance prevented the participant or beneficiary from presenting to a participating hospital for the provision of such services.

"(iv) NO GOOD FAITH EFFORT TO INFORM OF CHANGE IN PARTICIPATION DURING A CONTRACT YEAR.—The status of the hospital changed from a participating hospital to a nonparticipating hospital with respect to emergency services during a contract year and the plan or issuer failed to

make a good faith effort to notify the participant or beneficiary involved of such change.

"(v) OTHER CONDITIONS.—There were other factors (such as those identified in guidelines) that prevented the participant or beneficiary from controlling selection of the hospital in which the services were provided.

"(b) ASSURING COORDINATED COVERAGE OF MAINTENANCE CARE AND POST-STABILIZATION CARE.—

"(1) IN GENERAL.—In the case of a participant or beneficiary who is covered under a group health plan (or under health insurance coverage issued by a health insurance issuer offered in connection with such a plan) and who has received emergency services pursuant to a screening evaluation conducted (or supervised) by a treating physician at a hospital that is a nonparticipating provider with respect to emergency services, if—

"(A) pursuant to such evaluation, the physician identifies post-stabilization care (as defined in paragraph (3)(B)) that is required by the participant or beneficiary,

"(B) the plan or coverage provides benefits with respect to the care so identified and the plan requires (but for this subsection) an affirmative prior authorization determination as a condition of coverage of such care, and

"(C) the treating physician (or another individual acting on behalf of such physician) initiates, not later than 30 minutes after the time the treating physician determines that the condition of the participant or beneficiary is stabilized, a good faith effort to contact a physician or other person authorized by the plan or issuer (by telephone or other means) to obtain an affirmative prior authorization determination with respect to the care,

then, without regard to terms and conditions specified in paragraph (2) the plan or issuer shall cover maintenance care (as defined in paragraph (3)(A)) furnished to the participant or beneficiary during the period specified in paragraph (4) and shall cover post-stabilization care furnished to the participant or beneficiary during the period beginning under paragraph (5) and ending under paragraph (6).

"(2) TERMS AND CONDITIONS WAIVED.—The terms and conditions (of a plan or coverage) described in this paragraph that are waived under paragraph (1) are as follows:

"(A) The need for any prior authorization determination.

"(B) Any limitation on coverage based on whether or not the physician or provider furnishing the care is a participating physician or provider with respect to such care.

"(C) Any other term or condition of the plan or coverage (other than an exclusion of benefits, or an affiliation or waiting period, permitted under section 9801 and other than a requirement relating to medical necessity for coverage of benefits).

"(3) MAINTENANCE CARE AND POST-STABILIZATION CARE DEFINED.—In this subsection:

"(A) MAINTENANCE CARE.—The term 'maintenance care' means, with respect to an individual who is stabilized after provision of emergency services, medically necessary items and services (other than emergency services) that are required by the individual to ensure

that the individual remains stabilized during the period described in paragraph (4).

"(B) POST-STABILIZATION CARE.—The term 'post-stabilization care' means, with respect to an individual who is determined to be stable pursuant to a medical screening examination or who is stabilized after provision of emergency services, medically necessary items and services (other than emergency services and other than maintenance care) that are required by the individual.

"(4) PERIOD OF REQUIRED COVERAGE OF MAINTENANCE CARE.—The period of required coverage of maintenance care of an individual under this subsection begins at the time of the request (or the initiation of the good faith effort to make the request) under paragraph (1)(C) and ends when—

"(A) the individual is discharged from the hospital;

"(B) a physician (designated by the plan or issuer involved) and with privileges at the hospital involved arrives at the emergency department of the hospital and assumes responsibility with respect to the treatment of the individual; or

"(C) the treating physician and the plan or issuer agree to another arrangement with respect to the care of the individual.

"(5) WHEN POST-STABILIZATION CARE REQUIRED TO BE COVERED.—

"(A) WHEN TREATING PHYSICIAN UNABLE TO COMMUNICATE REQUEST.—If the treating physician or other individual makes the good faith effort to request authorization under paragraph (1)(C) but is unable to communicate the request directly with an authorized person referred to in such paragraph within 30 minutes after the time of initiating such effort, then post-stabilization care is required to be covered under this subsection beginning at the end of such 30-minute period.

"(B) WHEN ABLE TO COMMUNICATE REQUEST, AND NO TIMELY RESPONSE.—

"(i) IN GENERAL.—If the treating physician or other individual under paragraph (1)(C) is able to communicate the request within the 30-minute period described in subparagraph (A), the post-stabilization care requested is required to be covered under this subsection beginning 30

minutes after the time when the plan or issuer receives the request unless a person authorized by the plan or issuer involved communicates (or makes a good faith effort to communicate) a denial of the request for the prior authorization determination within 30 minutes of the time when the plan or issuer receives the request and the treating physician does not request under clause (ii) to communicate directly with an authorized physician concerning the denial.

"(ii) REQUEST FOR DIRECT PHYSICIAN-TO-PHYSICIAN COMMUNICATION CONCERNING DENIAL.—If a denial of a request is communicated under clause (i), the treating physician may request to communicate respecting the denial directly with a physician who is authorized by the plan or issuer to deny or affirm such a denial.

"(C) WHEN NO TIMELY RESPONSE TO REQUEST FOR PHYSICIAN-TO-PHYSICIAN COMMUNICATION.—If a request for physician-to-physician communication is made under subparagraph (B)(ii), the post-stabilization care requested is required to be covered under this subsection beginning 30 minutes after the time when the plan or issuer receives the request from a treating physician unless a physician, who is authorized by the plan or issuer to reverse or affirm the initial denial of the care, communicates (or makes a good faith effort to communicate) directly with the treating physician within such 30-minute period.

"(D) DISAGREEMENTS OVER POST-STABILIZATION CARE.—If, after a direct physician-to-physician communication under subparagraph (C), the denial of the request for the post-stabilization care is not reversed and the treating physician communicates to the plan or issuer involved a disagreement with such decision, the post-stabilization care requested is required to be covered under this subsection beginning as follows:

"(i) DELAY TO ALLOW FOR PROMPT ARRIVAL OF PHYSICIAN ASSUMING RESPONSIBILITY.—If the plan or issuer communicates that a physician (designated by the plan or issuer) with privileges at the hospital involved will arrive promptly (as determined under guidelines) at the emergency department of the hospital in order to assume responsibility with respect to the treatment of the participant or beneficiary involved, the required coverage of the post-stabilization care begins after the passage of such time period as would allow the prompt arrival of such a physician.

"(ii) OTHER CASES.—If the plan or issuer does not so communicate, the required coverage of the post-stabilization care begins immediately.

"(6) NO REQUIREMENT OF COVERAGE OF POST-STABILIZATION CARE IF ALTERNATE PLAN OF TREATMENT.—

"(A) IN GENERAL.—Coverage of post-stabilization care is not required under this subsection with respect to an individual when—

"(i) subject to subparagraph (B), a physician (designated by the plan or issuer involved) and with privileges at the hospital involved arrives at the emergency department of the hospital and assumes responsibility with respect to the treatment of the individual; or

"(ii) the treating physician and the plan or issuer agree to another arrangement with respect to the post-stabilization care (such as an appropriate transfer of the individual involved to another facility or an appointment for timely followup treatment for the individual).

"(B) SPECIAL RULE WHERE ONCE CARE INITIATED.—Required coverage of requested post-stabilization care shall not end by reason of subparagraph (A)(i) during an episode of care (as determined by guidelines) if the treating physician initiated such care (consistent with a previous paragraph) before the arrival of a physician described in such subparagraph.

"(7) CONSTRUCTION.—Nothing in this subsection shall be construed as—

"(A) preventing a plan or issuer from authorizing coverage of maintenance care or post-stabilization care in advance or at any time; or

"(B) preventing a treating physician or other individual described in paragraph (1)(C) and a plan or issuer from agreeing to modify any of the time periods specified in paragraph (5) as it relates to cases involving such persons.

"(c) LIMITS ON COST-SHARING FOR SERVICES FURNISHED IN EMERGENCY DEPARTMENTS.—If a group health plan provides any benefits with respect to emergency services, the plan (or a health insurance issuer offering health insurance coverage in connection with such a plan) may impose cost sharing with respect to such services only if the following conditions are met:

"(1) LIMITATIONS ON COST-SHARING DIFFERENTIAL FOR NONPARTICIPATING PROVIDERS.—

"(A) NO DIFFERENTIAL FOR CERTAIN SERVICES.—In the case of services furnished under the circumstances described in clause (i), (ii), or (iii) of subsection (a)(3)(B) (relating to circumstances beyond the control of the beneficiary, the likelihood of an adverse health consequence based on layperson's judgment, and physician referral), the cost-sharing for such

services provided by a nonparticipating provider or physician does not exceed the cost-sharing for such services provided by a participating provider or physician.

"(B) ONLY REASONABLE DIFFERENTIAL FOR OTHER SERVICES.—In the case of other emergency services, any differential by which the cost-sharing for such services provided by a nonparticipating provider or physician exceeds the cost-sharing for such services provided by a participating provider or physician is reasonable (as determined under guidelines).

"(2) ONLY REASONABLE DIFFERENTIAL BETWEEN EMERGENCY SERVICES AND OTHER SERVICES.—Any differential by which the cost-sharing for services furnished in an emergency department exceeds the cost-sharing for such services furnished in another setting is reasonable (as determined under guidelines).

"(3) CONSTRUCTION.—Nothing in paragraph (1)(B) or (2) shall be construed as authorizing guidelines other than guidelines that establish maximum cost-sharing differentials.

"(d) INFORMATION ON ACCESS TO EMERGENCY SERVICES.—A group health plan (or a health insurance

issuer, to the extent a health insurance issuer offers group health insurance coverage in connection with such a plan) shall provide education to participants and beneficiaries of the plan on—

"(1) coverage of emergency services (as defined in subsection (a)(2)(B)) by the plan in accordance with the provisions of this section,

"(2) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent,

"(3) any cost sharing applicable to emergency services,

"(4) the process and procedures of the plan for obtaining emergency services, and

"(5) the locations of—

"(A) emergency departments, and

"(B) other settings,

in which participating physicians and hospitals provide emergency services and post-stabilization care.

"(e) GENERAL DEFINITIONS.—For purposes of this section:

"(1) COST SHARING.—The term 'cost sharing' means any deductible, coinsurance amount, copayment or other out-of-pocket payment (other than premiums or enrollment fees) that a group health

plan (or a health insurance issuer offering group health insurance issuer in connection with such a plan) imposes on participants and beneficiaries of the plan with respect to the coverage of benefits.

"(2) GOOD FAITH EFFORT.—The term 'good faith effort' has the meaning given such term in guidelines and requires such appropriate documentation as is specified under such guidelines.

"(3) GUIDELINES.—The term 'guidelines' means guidelines established in accordance with section 7 of the Access to Emergency Medical Services Act of 1997.

"(4) NONPARTICIPATING PHYSICIAN OR PROVIDER.—The term 'nonparticipating physician or provider' means, with respect to health care items and services furnished to a participant or beneficiary of a group health plan, a physician or provider that is not a participating physician or provider for such services.

"(5) PARTICIPATING PHYSICIAN OR PROVIDER.—The term 'participating physician or provider' means, with respect to health care items and services furnished to a participant or beneficiary of a group health plan, a physician or provider that furnishes such items and services under a contract

or other arrangement with such plan (or with a health insurance issuer offering group health insurance coverage in connection with such a plan).

"(6) PRIOR AUTHORIZATION DETERMINATION.—The term 'prior authorization determination' means, with respect to items and services for which coverage may be provided under a group health plan, a determination (before the provision of the items and services and as a condition of coverage of the items and services under the plan) of whether or not such items and services will be covered under the plan.

"(7) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide (in complying with section 1867 of the Social Security Act) such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from the facility.

"(8) STABILIZED.—The term 'stabilized' means, with respect to an emergency medical condition, that no material deterioration of the condition

is likely, within reasonable medical probability, to result from or occur before an individual can be transferred from the facility, in compliance with the requirements of section 1867 of the Social Security Act.

"(9) TREATING PHYSICIAN.—The term 'treating physician' includes a treating health care professional who is licensed under State law to provide emergency services other than under the supervision of a physician."

(b) CONFORMING AMENDMENTS.—

(1) Chapter 100 of such Code (as added by section 401 of the Health Insurance Portability and Accountability Act of 1996 and as previously amended by this section) is further amended—

(A) in the last sentence of section 9801(c)(1), by striking "section 9805(c)" and inserting "section 9832(c)";

(B) in section 9831(b), by striking "9805(c)(1)" and inserting "9832(c)(1)";

(C) in section 9831(c)(1), by striking "9805(c)(2)" and inserting "9832(c)(2)";

(D) in section 9831(c)(2), by striking "9805(c)(3)" and inserting "9832(c)(3)"; and

(E) in section 9831(c)(3), by striking "9805(c)(4)" and inserting "9832(c)(4)".

(2) Section 4980D of such Code (as added by section 402 of the Health Insurance Portability and Accountability Act of 1996) is amended—

(A) in subsection (c)(3)(B)(i)(I), by striking "9805(d)(3)" and inserting "9832(d)(3)";

(B) in subsection (d)(1), by inserting "(other than a failure attributable to section 9811)" after "on any failure";

(C) in subsection (d)(3), by striking "9805" and inserting "9832";

(D) in subsection (f)(1), by striking "9805(a)" and inserting "9832(a)".

(3) The table of subtitles for such Code is amended by striking the item relating to subtitle K (as added by section 401(b) of the Health Insurance Portability and Accountability Act of 1996) and inserting the following new item:

"SUBTITLE K. Group health plan requirements."

(c) EFFECTIVE DATE.—(1) Subject to paragraph (2), the amendments made by this section shall apply to group health plans for plan years beginning on or after 18 months after the date of the enactment of this Act.

(2) In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements

between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) 18 months after the date of the enactment of this Act.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

"SEC. 713. ASSURING EQUITABLE COVERAGE OF EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.

"(a) PROHIBITION OF CERTAIN RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—

"(1) IN GENERAL.—If a group health plan provides any benefits with respect to emergency services (as defined in paragraph (2)(B)), the plan (and any health insurance issuer offering health insurance coverage in connection with such a plan) shall cover emergency services furnished to a participant or beneficiary of the plan—

"(A) without the need for any prior authorization determination,

"(B) subject to paragraph (3), whether or not the physician or provider furnishing such services is a participating physician or provider with respect to such services, and

"(C) subject to paragraph (3), without regard to any other term or condition of such plan or coverage (other than an exclusion of benefits, or an affiliation or waiting period, permitted under section 701).

"(2) EMERGENCY SERVICES; EMERGENCY MEDICAL CONDITION.—For purposes of this section—

"(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

"(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

"(ii) serious impairment to bodily functions, or

"(iii) serious dysfunction of any bodily organ or part.

"(B) EMERGENCY SERVICES.—The term 'emergency services' means—

"(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a

hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition (as defined in subparagraph (A)), and

"(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient.

"(C) TRAUMA AND BURN CENTERS.—The provisions of clause (ii) of subparagraph (B) apply to a trauma or burn center, in a hospital, that—

"(i) is designated by the State, a regional authority of the State, or by the designee of the State, or

"(ii) is in a State that has not made such designations and meets medically recognized national standards.

"(3) APPLICATION OF NETWORK RESTRICTION PERMITTED IN CERTAIN CASES.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), if a group health plan (and

an issuer of health insurance coverage in connection with such a plan) denies, limits, or otherwise differentiates in coverage or payment for benefits other than emergency services on the basis that the physician or provider of such services is a nonparticipating physician or provider, the plan and issuer may deny, limit, or differentiate in coverage or payment for emergency services on such basis.

"(B) NETWORK RESTRICTIONS NOT PERMITTED IN CERTAIN EXCEPTIONAL CASES.—The denial or limitation of, or differentiation in, coverage or payment of benefits for emergency services under subparagraph (A) shall not apply in the following cases:

"(i) CIRCUMSTANCES BEYOND CONTROL OF PARTICIPANT OR BENEFICIARY.—The participant or beneficiary is unable to go to a participating hospital for such services due to circumstances beyond the control of the participant or beneficiary (as determined consistent with guidelines and subparagraph (C)).

"(ii) LIKELIHOOD OF AN ADVERSE HEALTH CONSEQUENCE BASED ON

LAYPERSON'S JUDGMENT.—A prudent layperson possessing an average knowledge of health and medicine could reasonably believe that, under the circumstances and consistent with guidelines, the time required to go to a participating hospital for such services could result in any of the adverse health consequences described in a clause of subsection (a)(2)(A).

"(iii) PHYSICIAN REFERRAL.—A participating physician or other person authorized by the plan refers the participant or beneficiary to an emergency department of a hospital and does not specify an emergency department of a hospital that is a participating hospital with respect to such services.

"(C) APPLICATION OF 'BEYOND CONTROL' STANDARDS.—For purposes of applying subparagraph (B)(i), receipt of emergency services from a nonparticipating hospital shall be treated under the guidelines as being 'due to circumstances beyond the control of the participant or beneficiary' if any of the following conditions are met:

"(i) UNCONSCIOUS.—The participant or beneficiary was unconscious or in an otherwise altered mental state at the time of initiation of the services.

"(ii) AMBULANCE DELIVERY.—The participant or beneficiary was transported by an ambulance or other emergency vehicle directed by a person other than the participant or beneficiary to the nonparticipating hospital in which the services were provided.

"(iii) NATURAL DISASTER.—A natural disaster or civil disturbance prevented the participant or beneficiary from presenting to a participating hospital for the provision of such services.

"(iv) NO GOOD FAITH EFFORT TO INFORM OF CHANGE IN PARTICIPATION DURING A CONTRACT YEAR.—The status of the hospital changed from a participating hospital to a nonparticipating hospital with respect to emergency services during a contract year and the plan or issuer failed to

make a good faith effort to notify the participant or beneficiary involved of such change.

"(v) OTHER CONDITIONS.—There were other factors (such as those identified in guidelines) that prevented the participant or beneficiary from controlling selection of the hospital in which the services were provided.

"(b) ASSURING COORDINATED COVERAGE OF MAINTENANCE CARE AND POST-STABILIZATION CARE.—

"(1) IN GENERAL.—In the case of a participant or beneficiary who is covered under a group health plan (or under health insurance coverage issued by a health insurance issuer offered in connection with such a plan) and who has received emergency services pursuant to a screening evaluation conducted (or supervised) by a treating physician at a hospital that is a nonparticipating provider with respect to emergency services, if—

"(A) pursuant to such evaluation, the physician identifies post-stabilization care (as defined in paragraph (3)(B)) that is required by the participant or beneficiary,

"(B) the plan or coverage provides benefits with respect to the care so identified and the plan requires (but for this subsection) an affirmative prior authorization determination as a condition of coverage of such care, and

"(C) the treating physician (or another individual acting on behalf of such physician) initiates, not later than 30 minutes after the time the treating physician determines that the condition of the participant or beneficiary is stabilized, a good faith effort to contact a physician or other person authorized by the plan or issuer (by telephone or other means) to obtain an affirmative prior authorization determination with respect to the care,

then, without regard to terms and conditions specified in paragraph (2) the plan or issuer shall cover maintenance care (as defined in paragraph (3)(A)) furnished to the participant or beneficiary during the period specified in paragraph (4) and shall cover post-stabilization care furnished to the participant or beneficiary during the period beginning under paragraph (5) and ending under paragraph (6).

"(2) TERMS AND CONDITIONS WAIVED.—The terms and conditions (of a plan or coverage) described in this paragraph that are waived under paragraph (1) are as follows:

"(A) The need for any prior authorization determination.

"(B) Any limitation on coverage based on whether or not the physician or provider furnishing the care is a participating physician or provider with respect to such care.

"(C) Any other term or condition of the plan or coverage (other than an exclusion of benefits, or an affiliation or waiting period, permitted under section 701 and other than a requirement relating to medical necessity for coverage of benefits).

"(3) MAINTENANCE CARE AND POST-STABILIZATION CARE DEFINED.—In this subsection:

"(A) MAINTENANCE CARE.—The term 'maintenance care' means, with respect to an individual who is stabilized after provision of emergency services, medically necessary items and services (other than emergency services) that are required by the individual to ensure

that the individual remains stabilized during the period described in paragraph (4).

"(B) POST-STABILIZATION CARE.—The term 'post-stabilization care' means, with respect to an individual who is determined to be stable pursuant to a medical screening examination or who is stabilized after provision of emergency services, medically necessary items and services (other than emergency services and other than maintenance care) that are required by the individual.

"(4) PERIOD OF REQUIRED COVERAGE OF MAINTENANCE CARE.—The period of required coverage of maintenance care of an individual under this subsection begins at the time of the request (or the initiation of the good faith effort to make the request) under paragraph (1)(C) and ends when—

"(A) the individual is discharged from the hospital;

"(B) a physician (designated by the plan or issuer involved) and with privileges at the hospital involved arrives at the emergency department of the hospital and assumes responsibility with respect to the treatment of the individual; or

"(C) the treating physician and the plan or issuer agree to another arrangement with respect to the care of the individual.

"(5) WHEN POST-STABILIZATION CARE REQUIRED TO BE COVERED.—

"(A) WHEN TREATING PHYSICIAN UNABLE TO COMMUNICATE REQUEST.—If the treating physician or other individual makes the good faith effort to request authorization under paragraph (1)(C) but is unable to communicate the request directly with an authorized person referred to in such paragraph within 30 minutes after the time of initiating such effort, then post-stabilization care is required to be covered under this subsection beginning at the end of such 30-minute period.

"(B) WHEN ABLE TO COMMUNICATE REQUEST, AND NO TIMELY RESPONSE.—

"(i) IN GENERAL.—If the treating physician or other individual under paragraph (1)(C) is able to communicate the request within the 30-minute period described in subparagraph (A), the post-stabilization care requested is required to be covered under this subsection beginning 30

minutes after the time when the plan or issuer receives the request unless a person authorized by the plan or issuer involved communicates (or makes a good faith effort to communicate) a denial of the request for the prior authorization determination within 30 minutes of the time when the plan or issuer receives the request and the treating physician does not request under clause (ii) to communicate directly with an authorized physician concerning the denial.

"(ii) REQUEST FOR DIRECT PHYSICIAN-TO-PHYSICIAN COMMUNICATION CONCERNING DENIAL.—If a denial of a request is communicated under clause (i), the treating physician may request to communicate respecting the denial directly with a physician who is authorized by the plan or issuer to deny or affirm such a denial.

"(C) WHEN NO TIMELY RESPONSE TO REQUEST FOR PHYSICIAN-TO-PHYSICIAN COMMUNICATION.—If a request for physician-to-physician communication is made under subparagraph (B)(ii), the post-stabilization care requested is required to be covered under this subsection beginning 30 minutes after the time when the plan or issuer receives the request from a treating physician unless a physician, who is authorized by the plan or issuer to reverse or affirm the initial denial of the care, communicates (or makes a good faith effort to communicate) directly with the treating physician within such 30-minute period.

"(D) DISAGREEMENTS OVER POST-STABILIZATION CARE.—If, after a direct physician-to-physician communication under subparagraph (C), the denial of the request for the post-stabilization care is not reversed and the treating physician communicates to the plan or issuer involved a disagreement with such decision, the post-stabilization care requested is required to be covered under this subsection beginning as follows:

"(i) DELAY TO ALLOW FOR PROMPT ARRIVAL OF PHYSICIAN ASSUMING RESPONSIBILITY.—If the plan or issuer communicates that a physician (designated by the plan or issuer) with privileges at the hospital involved will arrive promptly (as determined under guidelines) at the emergency department of the hospital in order to assume responsibility with respect to the treatment of the participant or beneficiary involved, the required coverage of the post-stabilization care begins after the passage of such time period as would allow the prompt arrival of such a physician.

"(ii) OTHER CASES.—If the plan or issuer does not so communicate, the required coverage of the post-stabilization care begins immediately.

"(6) NO REQUIREMENT OF COVERAGE OF POST-STABILIZATION CARE IF ALTERNATE PLAN OF TREATMENT.—

"(A) IN GENERAL.—Coverage of post-stabilization care is not required under this subsection with respect to an individual when—

"(i) subject to subparagraph (B), a physician (designated by the plan or issuer involved) and with privileges at the hospital involved arrives at the emergency department of the hospital and assumes responsibility with respect to the treatment of the individual; or

"(ii) the treating physician and the plan or issuer agree to another arrangement with respect to the post-stabilization care (such as an appropriate transfer of the individual involved to another facility or an appointment for timely followup treatment for the individual).

"(B) SPECIAL RULE WHERE ONCE CARE INITIATED.—Required coverage of requested post-stabilization care shall not end by reason of subparagraph (A)(i) during an episode of care (as determined by guidelines) if the treating physician initiated such care (consistent with a previous paragraph) before the arrival of a physician described in such subparagraph.

"(7) CONSTRUCTION.—Nothing in this subsection shall be construed as—

"(A) preventing a plan or issuer from authorizing coverage of maintenance care or post-stabilization care in advance or at any time; or

"(B) preventing a treating physician or other individual described in paragraph (1)(C) and a plan or issuer from agreeing to modify any of the time periods specified in paragraph (5) as it relates to cases involving such persons.

"(c) LIMITS ON COST-SHARING FOR SERVICES FURNISHED IN EMERGENCY DEPARTMENTS.—If a group health plan provides any benefits with respect to emergency services, the plan (or a health insurance issuer offering health insurance coverage in connection with such a plan) may impose cost sharing with respect to such services only if the following conditions are met:

"(1) LIMITATIONS ON COST-SHARING DIFFERENTIAL FOR NONPARTICIPATING PROVIDERS.—

"(A) NO DIFFERENTIAL FOR CERTAIN SERVICES.—In the case of services furnished under the circumstances described in clause (i), (ii), or (iii) of subsection (a)(3)(B) (relating to circumstances beyond the control of the beneficiary, the likelihood of an adverse health consequence based on layperson's judgment, and physician referral), the cost-sharing for such

services provided by a nonparticipating provider or physician does not exceed the cost-sharing for such services provided by a participating provider or physician.

"(B) ONLY REASONABLE DIFFERENTIAL FOR OTHER SERVICES.—In the case of other emergency services, any differential by which the cost-sharing for such services provided by a nonparticipating provider or physician exceeds the cost-sharing for such services provided by a participating provider or physician is reasonable (as determined under guidelines).

"(2) ONLY REASONABLE DIFFERENTIAL BETWEEN EMERGENCY SERVICES AND OTHER SERVICES.—Any differential by which the cost-sharing for services furnished in an emergency department exceeds the cost-sharing for such services furnished in another setting is reasonable (as determined under guidelines).

"(3) CONSTRUCTION.—Nothing in paragraph (1)(B) or (2) shall be construed as authorizing guidelines other than guidelines that establish maximum cost-sharing differentials.

"(d) INFORMATION ON ACCESS TO EMERGENCY SERVICES.—A group health plan (or a health insurance

issuer, to the extent a health insurance issuer offers group health insurance coverage in connection with such a plan) shall provide education to participants and beneficiaries of the plan on—

"(1) coverage of emergency services (as defined in subsection (a)(2)(B)) by the plan in accordance with the provisions of this section,

"(2) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent,

"(3) any cost sharing applicable to emergency services,

"(4) the process and procedures of the plan for obtaining emergency services, and

"(5) the locations of—

"(A) emergency departments, and

"(B) other settings,

in which participating physicians and hospitals provide emergency services and post-stabilization care.

"(e) GENERAL DEFINITIONS.—For purposes of this section:

"(1) COST SHARING.—The term 'cost sharing' means any deductible, coinsurance amount, copayment or other out-of-pocket payment (other than premiums or enrollment fees) that a group health

plan (or a health insurance issuer offering group health insurance issuer in connection with such a plan) imposes on participants and beneficiaries of the plan with respect to the coverage of benefits.

"(2) GOOD FAITH EFFORT.—The term 'good faith effort' has the meaning given such term in guidelines and requires such appropriate documentation as is specified under such guidelines.

"(3) GUIDELINES.—The term 'guidelines' means guidelines established in accordance with section 7 of the Access to Emergency Medical Services Act of 1997.

"(4) NONPARTICIPATING PHYSICIAN OR PROVIDER.—The term 'nonparticipating physician or provider' means, with respect to health care items and services furnished to a participant or beneficiary of a group health plan, a physician or provider that is not a participating physician or provider for such services.

"(5) PARTICIPATING PHYSICIAN OR PROVIDER.—The term 'participating physician or provider' means, with respect to health care items and services furnished to a participant or beneficiary of a group health plan, a physician or provider that furnishes such items and services under a contract

or other arrangement with such plan (or with a health insurance issuer offering group health insurance coverage in connection with such a plan).

"(6) PRIOR AUTHORIZATION DETERMINATION.—The term 'prior authorization determination' means, with respect to items and services for which coverage may be provided under a group health plan, a determination (before the provision of the items and services and as a condition of coverage of the items and services under the plan) of whether or not such items and services will be covered under the plan.

"(7) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide (in complying with section 1867 of the Social Security Act) such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from the facility.

"(8) STABILIZED.—The term 'stabilized' means, with respect to an emergency medical condition, that no material deterioration of the condition

is likely, within reasonable medical probability, to result from or occur before an individual can be transferred from the facility, in compliance with the requirements of section 1867 of the Social Security Act.

"(9) TREATING PHYSICIAN.—The term 'treating physician' includes a treating health care professional who is licensed under State law to provide emergency services other than under the supervision of a physician.

"(f) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—The provisions of section 731(a) (relating to State authority to provide for standards and requirements for health insurance issuers to the extent the standards and requirements do not prevent the application of a requirement of this part) apply with respect to the requirements of this section.".

(b) CONFORMING AMENDMENTS.—

(1) Section 731(c) of such Act (29 U.S.C. 1191(c)), as amended by section 603(b)(1) of Public Law 104–204, is amended by striking "section 711" and inserting "sections 711 and 713".

(2) Section 732(a) of such Act (29 U.S.C. 1191a(a)), as amended by section 603(b)(2) of Public Law 104–204, is amended by striking "section 711" and inserting "sections 711 and 713".

(3) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 712 the following new item:

"Sec. 713. Assuring equitable coverage of emergency services, maintenance care, and post-stabilization care.".

(c) EFFECTIVE DATE.—(1) Subject to paragraph (2), the amendments made by this section shall apply to group health plans for plan years beginning on or after the date that is 18 months after the date of the enactment of this Act.

(2) In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) 18 months after the date of the enactment of this Act.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 4. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2706. ASSURING EQUITABLE COVERAGE OF EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.

"(a) PROHIBITION OF CERTAIN RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—

"(1) IN GENERAL.—If a group health plan provides any benefits with respect to emergency services (as defined in paragraph (2)(B)), the plan (and any health insurance issuer offering health insurance coverage in connection with such a plan) shall cover emergency services furnished to a participant or beneficiary of the plan—

"(A) without the need for any prior authorization determination,

"(B) subject to paragraph (3), whether or not the physician or provider furnishing such services is a participating physician or provider with respect to such services, and

"(C) subject to paragraph (3), without regard to any other term or condition of such plan or coverage (other than an exclusion of benefits, or an affiliation or waiting period, permitted under section 2701).

"(2) EMERGENCY SERVICES; EMERGENCY MEDICAL CONDITION.—For purposes of this section—

"(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

"(i) placing the health of the individual (or, with respect to a pregnant woman,

the health of the woman or her unborn child) in serious jeopardy,

"(ii) serious impairment to bodily functions, or

"(iii) serious dysfunction of any bodily organ or part.

"(B) EMERGENCY SERVICES.—The term 'emergency services' means—

"(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition (as defined in subparagraph (A)), and

"(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient.

"(C) TRAUMA AND BURN CENTERS.—The provisions of clause (ii) of subparagraph (B)

apply to a trauma or burn center, in a hospital, that—

"(i) is designated by the State, a regional authority of the State, or by the designee of the State, or

"(ii) is in a State that has not made such designations and meets medically recognized national standards.

"(3) APPLICATION OF NETWORK RESTRICTION PERMITTED IN CERTAIN CASES.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), if a group health plan (and an issuer of health insurance coverage in connection with such a plan) denies, limits, or otherwise differentiates in coverage or payment for benefits other than emergency services on the basis that the physician or provider of such services is a nonparticipating physician or provider, the plan and issuer may deny, limit, or differentiate in coverage or payment for emergency services on such basis.

"(B) NETWORK RESTRICTIONS NOT PERMITTED IN CERTAIN EXCEPTIONAL CASES.—The denial or limitation of, or differentiation in, coverage or payment of benefits for emergency

services under subparagraph (A) shall not apply in the following cases:

"(i) CIRCUMSTANCES BEYOND CONTROL OF PARTICIPANT OR BENEFICIARY.—The participant or beneficiary is unable to go to a participating hospital for such services due to circumstances beyond the control of the participant or beneficiary (as determined consistent with guidelines and subparagraph (C)).

"(ii) LIKELIHOOD OF AN ADVERSE HEALTH CONSEQUENCE BASED ON LAYPERSON'S JUDGMENT.—A prudent layperson possessing an average knowledge of health and medicine could reasonably believe that, under the circumstances and consistent with guidelines, the time required to go to a participating hospital for such services could result in any of the adverse health consequences described in a clause of subsection (a)(2)(A).

"(iii) PHYSICIAN REFERRAL.—A participating physician or other person authorized by the plan refers the participant or beneficiary to an emergency department

of a hospital and does not specify an emergency department of a hospital that is a participating hospital with respect to such services.

"(C) APPLICATION OF 'BEYOND CONTROL' STANDARDS.—For purposes of applying subparagraph (B)(i), receipt of emergency services from a nonparticipating hospital shall be treated under the guidelines as being 'due to circumstances beyond the control of the participant or beneficiary' if any of the following conditions are met:

"(i) UNCONSCIOUS.—The participant or beneficiary was unconscious or in an otherwise altered mental state at the time of initiation of the services.

"(ii) AMBULANCE DELIVERY.—The participant or beneficiary was transported by an ambulance or other emergency vehicle directed by a person other than the participant or beneficiary to the nonparticipating hospital in which the services were provided.

"(iii) NATURAL DISASTER.—A natural disaster or civil disturbance prevented the

participant or beneficiary from presenting to a participating hospital for the provision of such services.

"(iv) NO GOOD FAITH EFFORT TO INFORM OF CHANGE IN PARTICIPATION DURING A CONTRACT YEAR.—The status of the hospital changed from a participating hospital to a nonparticipating hospital with respect to emergency services during a contract year and the plan or issuer failed to make a good faith effort to notify the participant or beneficiary involved of such change.

"(v) OTHER CONDITIONS.—There were other factors (such as those identified in guidelines) that prevented the participant or beneficiary from controlling selection of the hospital in which the services were provided.

"(b) ASSURING COORDINATED COVERAGE OF MAINTENANCE CARE AND POST-STABILIZATION CARE.—

"(1) IN GENERAL.—In the case of a participant or beneficiary who is covered under a group health plan (or under health insurance coverage issued by a health insurance issuer offered in connection with

such a plan) and who has received emergency services pursuant to a screening evaluation conducted (or supervised) by a treating physician at a hospital that is a nonparticipating provider with respect to emergency services, if—

"(A) pursuant to such evaluation, the physician identifies post-stabilization care (as defined in paragraph (3)(B)) that is required by the participant or beneficiary,

"(B) the plan or coverage provides benefits with respect to the care so identified and the plan requires (but for this subsection) an affirmative prior authorization determination as a condition of coverage of such care, and

"(C) the treating physician (or another individual acting on behalf of such physician) initiates, not later than 30 minutes after the time the treating physician determines that the condition of the participant or beneficiary is stabilized, a good faith effort to contact a physician or other person authorized by the plan or issuer (by telephone or other means) to obtain an affirmative prior authorization determination with respect to the care,

then, without regard to terms and conditions specified in paragraph (2) the plan or issuer shall cover maintenance care (as defined in paragraph (3)(A)) furnished to the participant or beneficiary during the period specified in paragraph (4) and shall cover post-stabilization care furnished to the participant or beneficiary during the period beginning under paragraph (5) and ending under paragraph (6).

"(2) TERMS AND CONDITIONS WAIVED.—The terms and conditions (of a plan or coverage) described in this paragraph that are waived under paragraph (1) are as follows:

"(A) The need for any prior authorization determination.

"(B) Any limitation on coverage based on whether or not the physician or provider furnishing the care is a participating physician or provider with respect to such care.

"(C) Any other term or condition of the plan or coverage (other than an exclusion of benefits, or an affiliation or waiting period, permitted under section 2701 and other than a requirement relating to medical necessity for coverage of benefits).

"(3) MAINTENANCE CARE AND POST-STABILIZATION CARE DEFINED.—In this subsection:

"(A) MAINTENANCE CARE.—The term 'maintenance care' means, with respect to an individual who is stabilized after provision of emergency services, medically necessary items and services (other than emergency services) that are required by the individual to ensure that the individual remains stabilized during the period described in paragraph (4).

"(B) POST-STABILIZATION CARE.—The term 'post-stabilization care' means, with respect to an individual who is determined to be stable pursuant to a medical screening examination or who is stabilized after provision of emergency services, medically necessary items and services (other than emergency services and other than maintenance care) that are required by the individual.

"(4) PERIOD OF REQUIRED COVERAGE OF MAINTENANCE CARE.—The period of required coverage of maintenance care of an individual under this subsection begins at the time of the request (or the initiation of the good faith effort to make the request) under paragraph (1)(C) and ends when—

"(A) the individual is discharged from the hospital;

"(B) a physician (designated by the plan or issuer involved) and with privileges at the hospital involved arrives at the emergency department of the hospital and assumes responsibility with respect to the treatment of the individual; or

"(C) the treating physician and the plan or issuer agree to another arrangement with respect to the care of the individual.

"(5) WHEN POST-STABILIZATION CARE REQUIRED TO BE COVERED.—

"(A) WHEN TREATING PHYSICIAN UNABLE TO COMMUNICATE REQUEST.—If the treating physician or other individual makes the good faith effort to request authorization under paragraph (1)(C) but is unable to communicate the request directly with an authorized person referred to in such paragraph within 30 minutes after the time of initiating such effort, then post-stabilization care is required to be covered under this subsection beginning at the end of such 30-minute period.

"(B) WHEN ABLE TO COMMUNICATE REQUEST, AND NO TIMELY RESPONSE.—

"(i) IN GENERAL.—If the treating physician or other individual under paragraph (1)(C) is able to communicate the request within the 30-minute period described in subparagraph (A), the post-stabilization care requested is required to be covered under this subsection beginning 30 minutes after the time when the plan or issuer receives the request unless a person authorized by the plan or issuer involved communicates (or makes a good faith effort to communicate) a denial of the request for the prior authorization determination within 30 minutes of the time when the plan or issuer receives the request and the treating physician does not request under clause (ii) to communicate directly with an authorized physician concerning the denial.

"(ii) REQUEST FOR DIRECT PHYSICIAN-TO-PHYSICIAN COMMUNICATION CONCERNING DENIAL.—If a denial of a request is communicated under clause (i), the

treating physician may request to communicate respecting the denial directly with a physician who is authorized by the plan or issuer to deny or affirm such a denial.

"(C) WHEN NO TIMELY RESPONSE TO REQUEST FOR PHYSICIAN-TO-PHYSICIAN COMMUNICATION.—If a request for physician-to-physician communication is made under subparagraph (B)(ii), the post-stabilization care requested is required to be covered under this subsection beginning 30 minutes after the time when the plan or issuer receives the request from a treating physician unless a physician, who is authorized by the plan or issuer to reverse or affirm the initial denial of the care, communicates (or makes a good faith effort to communicate) directly with the treating physician within such 30-minute period.

"(D) DISAGREEMENTS OVER POST-STABILIZATION CARE.—If, after a direct physician-to-physician communication under subparagraph (C), the denial of the request for the post-stabilization care is not reversed and the treating physician communicates to the plan or

issuer involved a disagreement with such decision, the post-stabilization care requested is required to be covered under this subsection beginning as follows:

"(i) DELAY TO ALLOW FOR PROMPT ARRIVAL OF PHYSICIAN ASSUMING RESPONSIBILITY.—If the plan or issuer communicates that a physician (designated by the plan or issuer) with privileges at the hospital involved will arrive promptly (as determined under guidelines) at the emergency department of the hospital in order to assume responsibility with respect to the treatment of the participant or beneficiary involved, the required coverage of the post-stabilization care begins after the passage of such time period as would allow the prompt arrival of such a physician.

"(ii) OTHER CASES.—If the plan or issuer does not so communicate, the required coverage of the post-stabilization care begins immediately.

"(6) NO REQUIREMENT OF COVERAGE OF POST-STABILIZATION CARE IF ALTERNATE PLAN OF TREATMENT.—

"(A) IN GENERAL.—Coverage of post-stabilization care is not required under this subsection with respect to an individual when—

"(i) subject to subparagraph (B), a physician (designated by the plan or issuer involved) and with privileges at the hospital involved arrives at the emergency department of the hospital and assumes responsibility with respect to the treatment of the individual; or

"(ii) the treating physician and the plan or issuer agree to another arrangement with respect to the post-stabilization care (such as an appropriate transfer of the individual involved to another facility or an appointment for timely followup treatment for the individual).

"(B) SPECIAL RULE WHERE ONCE CARE INITIATED.—Required coverage of requested post-stabilization care shall not end by reason of subparagraph (A)(i) during an episode of care (as determined by guidelines) if the treating physician initiated such care (consistent with a previous paragraph) before the arrival of a physician described in such subparagraph.

"(7) CONSTRUCTION.—Nothing in this subsection shall be construed as—

"(A) preventing a plan or issuer from authorizing coverage of maintenance care or post-stabilization care in advance or at any time; or

"(B) preventing a treating physician or other individual described in paragraph (1)(C) and a plan or issuer from agreeing to modify any of the time periods specified in paragraph (5) as it relates to cases involving such persons.

"(c) LIMITS ON COST-SHARING FOR SERVICES FURNISHED IN EMERGENCY DEPARTMENTS.—If a group health plan provides any benefits with respect to emergency services, the plan (or a health insurance issuer offering health insurance coverage in connection with such a plan) may impose cost sharing with respect to such services only if the following conditions are met:

"(1) LIMITATIONS ON COST-SHARING DIFFERENTIAL FOR NONPARTICIPATING PROVIDERS.—

"(A) NO DIFFERENTIAL FOR CERTAIN SERVICES.—In the case of services furnished under the circumstances described in clause (i), (ii), or (iii) of subsection (a)(3)(B) (relating to

circumstances beyond the control of the beneficiary, the likelihood of an adverse health consequence based on layperson's judgment, and physician referral), the cost-sharing for such services provided by a nonparticipating provider or physician does not exceed the cost-sharing for such services provided by a participating provider or physician.

"(B) ONLY REASONABLE DIFFERENTIAL FOR OTHER SERVICES.—In the case of other emergency services, any differential by which the cost-sharing for such services provided by a nonparticipating provider or physician exceeds the cost-sharing for such services provided by a participating provider or physician is reasonable (as determined under guidelines).

"(2) ONLY REASONABLE DIFFERENTIAL BETWEEN EMERGENCY SERVICES AND OTHER SERVICES.—Any differential by which the cost-sharing for services furnished in an emergency department exceeds the cost-sharing for such services furnished in another setting is reasonable (as determined under guidelines).

"(3) CONSTRUCTION.—Nothing in paragraph (1)(B) or (2) shall be construed as authorizing

guidelines other than guidelines that establish maximum cost-sharing differentials.

"(d) INFORMATION ON ACCESS TO EMERGENCY SERVICES.—A group health plan (or a health insurance issuer, to the extent a health insurance issuer offers group health insurance coverage in connection with such a plan) shall provide education to participants and beneficiaries of the plan on—

"(1) coverage of emergency services (as defined in subsection (a)(2)(B)) by the plan in accordance with the provisions of this section,

"(2) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent,

"(3) any cost sharing applicable to emergency services,

"(4) the process and procedures of the plan for obtaining emergency services, and

"(5) the locations of—

"(A) emergency departments, and

"(B) other settings,

in which participating physicians and hospitals provide emergency services and post-stabilization care.

"(e) GENERAL DEFINITIONS.—For purposes of this section:

"(1) COST SHARING.—The term 'cost sharing' means any deductible, coinsurance amount, copayment or other out-of-pocket payment (other than premiums or enrollment fees) that a group health plan (or a health insurance issuer offering group health insurance issuer in connection with such a plan) imposes on participants and beneficiaries of the plan with respect to the coverage of benefits.

"(2) GOOD FAITH EFFORT.—The term 'good faith effort' has the meaning given such term in guidelines and requires such appropriate documentation as is specified under such guidelines.

"(3) GUIDELINES.—The term 'guidelines' means guidelines established in accordance with section 7 of the Access to Emergency Medical Services Act of 1997.

"(4) NONPARTICIPATING PHYSICIAN OR PROVIDER.—The term 'nonparticipating physician or provider' means, with respect to health care items and services furnished to a participant or beneficiary of a group health plan, a physician or provider that is not a participating physician or provider for such services.

"(5) PARTICIPATING PHYSICIAN OR PROVIDER.—The term 'participating physician or provider' means, with respect to health care items and services furnished to a participant or beneficiary of a group health plan, a physician or provider that furnishes such items and services under a contract or other arrangement with such plan (or with a health insurance issuer offering group health insurance coverage in connection with such a plan).

"(6) PRIOR AUTHORIZATION DETERMINATION.—The term 'prior authorization determination' means, with respect to items and services for which coverage may be provided under a group health plan, a determination (before the provision of the items and services and as a condition of coverage of the items and services under the plan) of whether or not such items and services will be covered under the plan.

"(7) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide (in complying with section 1867 of the Social Security Act) such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or

occur during the transfer of the individual from the facility.

"(8) STABILIZED.—The term 'stabilized' means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur before an individual can be transferred from the facility, in compliance with the requirements of section 1867 of the Social Security Act.

"(9) TREATING PHYSICIAN.—The term 'treating physician' includes a treating health care professional who is licensed under State law to provide emergency services other than under the supervision of a physician.

"(f) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—The provisions of section 2723(a) (relating to State authority to provide for standards and requirements for health insurance issuers to the extent the standards and requirements do not prevent the application of a requirement of this part) apply with respect to the requirements of this section.".

(b) CONFORMING AMENDMENT.—Section 2723(c) of such Act (42 U.S.C. 300gg–23(c)), as amended by section

604(b)(2) of Public Law 104–204, is amended by striking "section 2704" and inserting "sections 2704 and 2706".

(c) EFFECTIVE DATE.—(1) Subject to paragraph (2), the amendments made by this section shall apply to group health plans for plan years beginning on or after the date that is 18 months after the date of the enactment of this Act.

(2) In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) 18 months after the date of the enactment of this Act.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be

treated as a termination of such collective bargaining agreement.

SEC. 5. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.

(a) IN GENERAL.—Part B of title XXVII of the Public Health Service Act is amended—

(1) by redesignating the subpart 3 relating to other requirements as subpart 2, and

(2) by adding at the end of such subpart the following new section:

"SEC. 2752. ASSURING EQUITABLE COVERAGE OF EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.

"(a) IN GENERAL.—The provisions of section 2706 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group plan. In applying the previous sentence, the reference in section 2706(b)(2)(C) to section 2701 is deemed a reference to subpart 1 of this part.

"(b) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—The provisions of section 2762 (relating to State authority to

provide for standards and requirements for health insurance issuers to the extent the standards and requirements do not prevent the application of a requirement of this part) apply with respect to the requirements of this section.".

(b) CONFORMING AMENDMENT.—Section 2763(b)(2) of such Act (42 U.S.C. 300gg–63(b)(2)), as added by section 605(b)(3)(B) of Public Law 104–204, is amended by striking "section 2751" and inserting "sections 2751 and 2752".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the date that is 18 months after the date of the enactment of this Act.

SEC. 6. APPLICATION TO PRIVATE COVERAGE FOR MEDICARE AND MEDICAID BENEFICIARIES.

(a) MEDICARE.—Subparagraph (B) of section 1876(c)(4) of the Social Security Act (42 U.S.C. 1395mm(c)(4)) is amended to read as follows:

"(B) meets the requirements of section 2706 of the Public Health Service Act with respect to individuals enrolled with the organization under this section.".

(b) MEDICAID.—Title XIX of such Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1908 the following new section:

"ACCESS TO EMERGENCY SERVICES FOR BENEFICIARIES ENROLLED IN PRIVATE HEALTH PLANS

"SEC. 1909. (a) IN GENERAL.—A state plan may not be approved under this title unless the plan requires each health insurance issuer or other entity with a contract with such plan to provide coverage or benefits to individuals eligible for medical assistance under the plan to comply with the provisions of section 2706 of the Public Health Service Act with respect to such coverage or benefits.

"(b) COST SHARING.—Nothing in this section or section 2706(c) of the Public Health Service Act shall be construed as authorizing a health insurance issuer or entity to impose cost sharing with respect to the coverage or benefits described in subsection (a) that is inconsistent with the cost sharing that is otherwise permitted under this title.

"(c) WAIVERS PROHIBITED.—The requirement of subsection (a) may not be waived under section 1115 or section 1915(b) of the Social Security Act.".

(c) MEDICARE SELECT POLICIES.—Section 1882(t)(1) of such Act (42 U.S.C. 1395ss(t)(1)) is amended—

(1) in subparagraph (B), by inserting "subject to subparagraph (G)," after "(B)",

(2) by striking "and" at the end of subparagraph (E),

(3) by striking the period at the end of subparagraph (F) and inserting "; and", and

(4) by adding at the end the following new subparagraph:

"(G) the issuer of the policy complies with the requirements of section 2752 of the Public Health Service Act with respect to enrollees under this subsection.".

(d) EFFECTIVE DATES.—

(1) MEDICARE.—The amendment made by subsection (a) shall apply to eligible organizations under section 1876 of the Social Security Act for contract years beginning on or after the date that is 18 months after the date of the enactment of this Act.

(2) MEDICAID.—The amendment made by subsection (b) shall apply to State plans under title XIX of the Social Security Act for contract years beginning on or after the date that is 18 months after the date of the enactment of this Act.

(3) MEDICARE SELECT.—The amendments made by subsection (c) shall apply to policies for

contract years beginning on or after the date that is 18 months after the date of the enactment of this Act.

SEC. 7. ESTABLISHMENT OF GUIDELINES.

(a) IN GENERAL.—The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury (in this section referred to as "the Secretaries") shall, in accordance with the process described in subsection (b), jointly establish guidelines to carry out section 9811 of the Internal Revenue Code of 1986, section 713 of the Employee Retirement Income Security Act of 1974, and sections 2706 and 2752 of the Public Health Service Act, including all such guidelines as may be referred to in such sections.

(b) PROCESS.—

(1) ADVISORY PANEL.—Not later than 90 days after the date of the enactment of this Act, the Secretaries shall jointly establish an advisory panel to assist in the development of the guidelines referred to in subsection (a). The members of the panel shall include individuals representing—

(A) emergency medical personnel, including emergency physicians, emergency nurses, and other appropriate emergency health care professionals;

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(B) health insurance issuers, including at least one health maintenance organization;

(C) hospitals;

(D) employers;

(E) the States; and

(F) consumers.

(2) NOTICE AND COMMENT.—Not later than 180 days after the date of the enactment of this Act, the Secretaries shall jointly cause to have published in the Federal Register notice of proposed rulemaking on the guidelines referred to in subsection (a). Not later than 60 days after the close of the period for public comment on such guidelines, the Secretaries shall jointly cause to have published in the Federal Register a final rule establishing such guidelines.

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